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HOWARD K. KOH MD, MPH
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December 16, 1999

Dear Hospital CEO:

Last month, we wrote to you about our concerns and plans to address the serious issue of emergency department diversion of ambulances. At that time, we provided you with a short checklist of some recommended activities that hospitals could undertake to address the problem. We also informed you of our plans to develop Best Practices Guidelines for hospitals to use to prevent and to manage ambulance diversions.

We are pleased to be able to present you with an initial set of Best Practice Guidelines for your consideration and would like to thank the members of the Ambulance Diversion Task Force in assisting us in their development (see attached list of members). We hope that they prove helpful to hospitals in developing individual policies and procedures as well as in promoting system coordination between hospitals and with pre-hospital providers. Additional work will be taking place over the coming year to give further detail to the components of the Best Practice Guideline document.

We sought to present the Guidelines in a concise and logical way. Within broad activity categories are presented individual best practice principles. Should you or your staff have questions or require clarification about specific elements of the Guidelines, please do not hesitate to contact Brad Prenney at the Department of Public Health (617) 753-8400 or Leslie Kirle at the Massachusetts Hospital Association (781) 272-8000. The Association will also be sending out an advisory to hospital public relations contacts informing them of the release of the Guidelines and recommended steps to promote media awareness and coverage of the ambulance diversion issue.

In last month's correspondence to you, we also acknowledged the need to seek broad, long-term solutions that address the fundamental and structural challenges faced by hospitals, including financing, staff shortages and legislation and the task force is committed to looking at these issues.

In another development, the Massachusetts House of Representatives passed the EMS 2000 legislation, which should improve communication and coordination of emergency transport services. We will keep you informed as to the progress of this legislation over the next few months.

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We look forward to continued collaboration with you and the Ambulance Diversion Task Force on this important issue and welcome any comments on these Best Practice Guidelines or other steps that can be taken to ensure that our citizens have access to the best and most timely emergency care.

Sincerely,

Howard Koh MD MPH

Howard K. Koh, MD, MPH
Commissioner
Massachusetts Department of Public Health

Ronald Hollander
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BEST PRACTICE GUIDELINES FOR HOSPITALS REGARDING AMBULANCE DIVERSIONS

BACKGROUND AND STATEMENT OF PURPOSE

In 1988, the Massachusetts Hospital Association (MHA) published a report and recommendations of a task force convened in response to a dramatic increase in the frequency with which hospitals diverted incoming ambulance traffic from their emergency departments. The report, "Patient Overload and Ambulance Diversion," focused on three key areas: (1) internal hospital operating procedures and policies; (2) inter-hospital communications and (3) communications between hospitals, pre-hospital providers and the public.

The guidance provided in the 1988 report produced a number of improvements; most hospitals now have diversion policies in place, including policies to triage and to manage bed capacity; and communications between hospitals and pre-hospital providers have improved largely through the coordinated efforts between hospitals and Regional EMS Councils.

Despite the efforts expended over this past decade, many of the factors that contributed to the problem a decade ago continue to affect hospitals and pre-hospital providers today. In addition, many hospitals have closed and others have reduced staffing and beds, further reducing capacity within the system. The seasonal spike in utilization typically experienced by hospitals in winter months was more extreme the last two years, resulting in ambulance diversions increasing significantly in both frequency and duration. Variation in patterns of seasonal use also have become more volatile. While the utilization pattern was similar statewide not all hospitals shared the same experience. Occupancy rates were also higher during the winter of 1998 and 1999; averaging 75 percent of staffed beds and 79 percent of staffed beds when observation is included. Nearly all the increase was attributable to respiratory illnesses, including the flu, among the very old and very young.

Well over half of our hospitals, statewide, have had to go on diversion at one time or another this year. In one region of the state, virtually every hospital has been on diversion in 1999. That region has experienced a 46% increase in the frequency of diversions so far this year as compared to last year and has seen the total time the region's hospitals are on divert increase 63 percent.

Early in 1999, Howard K. Koh, MD, MPH, Commissioner of the Massachusetts Department of Public Health, in conjunction with the Massachusetts Hospital Association, convened a task force to study the current causes of ambulance diversions and to investigate immediate and long-term solutions to the problem. The task force included representation from the Massachusetts Medical Society, the Massachusetts College of Emergency Physicians, the Massachusetts Organization of Nurse Executives and the Regional EMS Councils among others.

The Commissioner's charge to the task force was to develop best practice guidelines for hospitals to use both to minimize the need to go on diversion and to ensure that the system responded in a coordinated and efficient manner when diversion became necessary. Like its predecessor a decade ago, the current ambulance diversion task force recognizes that ambulance diversions are less often a result of a sudden increase in ED census than a response to too few staffed beds elsewhere in the hospital, most commonly in critical care and/or intensive care units.

The accompanying document offers a comprehensive range of best practice principles that hospitals can consider adopting internally and which are meant to promote greater coordination among hospital and pre-hospital providers. These Best Practice Guidelines have drawn heavily from the experience and wisdom of the 1988 MHA Report and the recommendations of the previous Task Force.

BEST PRACTICE GUIDELINES FOR HOSPITALS REGARDING AMBULANCE DIVERSIONS

(A) Intra-Institutional Best Practices: What a hospital needs to do internally (prevention and planning activities)

Develop policies that address the causes for diversion and implement practices that minimize the need for diversion. These policies might include such elements as maximizing bed capacity and other steps internal to each hospital to maximize internal communication. Effective diversion policies may include consideration of triage or rescheduling of elective admissions and/or treat and transfer protocols.

- Maintain a daily bed management and tracking system to facilitate the flow of patients admitted and discharged. This system should allow the identification of the following:

  - Projected discharges
  - Scheduled admissions
  - Transfers out of ICUs to routine beds
  - Projected emergency admissions
  - Available beds by service, including critical care

- Develop diversion criteria and any relevant exceptions within the institution based on institution-specific needs and an analysis of the availability of external resources (e.g., other hospital emergency departments and in-patient services within the service area of the hospital).

- Determine who <u>specifically</u> makes the decisions to initiate a full or partial diversion and the process used for making the decision to divert, including internal and external communication channels. In developing communication channels consider:

  - Other hospitals in service area
  - Regional EMS/Pre-hospital providers
  - Municipal agencies (fire, police, health)
  - Press/Media

- In order to maximize bed utilization, notify the appropriate hospital staff as soon as it has been determined that a potential overload of patients might occur. In addition to notifying key personnel, it is essential to alert physicians of the high census and potential shortage of beds.

(B) Inter-Institutional/Service Best Practices: Meet and communicate with other hospitals and pre-hospital transport services BEFORE there is a need for diversion

- Once the plan has been developed internally, meet with other service area providers and pre-hospital transport services to discuss and refine your own plan, and come to a common understanding of what will happen in the event of a diversion

- Develop coordinated policies (agreements) with other hospitals in the same service area to include:

  - Communications
  - How to manage emergency transports when all are on diversion

- Develop coordinated policies (agreements) with Regional EMS and EMS providers

  - Defining by agreement how EMS providers shall proceed when there is a diversion
  - Defining by agreement exceptions to diversion
  - Defining by agreement who makes the decision to override the diversion decision
  - Defining by agreement the coordination of inter-facility transfers, in-patient bed capability with surrounding and network affiliated hospitals

(C) Communication and Coordination Best Practices: What actually happens once a diversion decision has been made

- Communicate diversion decision to other stakeholders

  - Notification of EMS system
  - Notification of other hospitals

- Manage diversion while diversion status is on-going

- Maintain ongoing communication with C-MED system

- Continue to monitor bed and ED capacity and notify C-MED system of any changes in diversion status

- Maintain and monitor data on frequency, duration, and reasons for diversion

- Coordinate media interactions with MHA and DPH

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